# ALL-PAYER FINANCING OF UNCOMPENSATED CARE: THE NEW JERSEY EXPERIENCE*

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UNCOMPENSATED or unpaid hospital care—care for those who cannot or will not pay—is a long-standing problem. At one time philanthropy was the principal support for hospital care for the poor. As third-party reimbursement became the norm, hospitals were able to finance unpaid care through increased charges to patients having third-party coverage. More recently, however, increases in the amount of uncompensated care, reductions in the federal government's payments for hospital services and greater price competition in the private sector have contributed to rapidly rising and inequitable charges to many third-party payers and growing deficits in those hospitals with too few charge-paying patients to bear the cost of unpaid care.

These developments threaten the ability of many hospitals to continue to provide care to the poor. As a result, many state governments have begun to study the issue of "medical indigency" and to propose ways to assure that the indigent have access to needed health care. There are two main types of proposed solutions. The first provides or expands a *medical entitlement* for the poor. Expansion of Medicaid eligibility or addition of a "medically needy" provision to reach some of those not reached by the basic Medicaid program would reduce the size of the uncompensated care problem faced by many hospitals. For those covered, it would also assure reasonable access to health care.

A second solution to the problem of medical indigency is the creation of a *financial entitlement* for hospitals that care for the indigent and others who do not pay. This approach does not directly entitle the poor to care, but indirectly achieves a similar end by guaranteeing some level of payment to

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hospitals for care provided to the poor. A special case of this approach is government "indigency grants" to hospitals, but grants usually cover only a fraction of the costs of uncompensated care, leaving the hospital at risk for the remainder. New Jersey's entitlement for hospitals goes further because it creates a legal right by which hospitals are indemnified against all reasonable costs incurred in treating those for whom this entitlement applies. In addition, New Jersey has chosen a particular way to finance this entitlement, which also deserves some attention.

This paper undertakes first to provide a technical description of how uncompensated hospital care is paid under New Jersey's prospective reimbursement system, in which acute care hospitals are paid a rate-per-case for inpatient services with patients classified according to Diagnosis Related Groups. Second, it describes those features of the system to pay for uncompensated care which raise important policy questions. These questions are discussed as they relate to the issues of access to care for the indigent, cost effectiveness and equity.

## The New Jersey Reimbursement System

Statutory authority for the New Jersey reimbursement system is provided by Public Law 1978, Chapter 83, which creates authority for hospital rates to be established for all purchasers of hospital services—hence the expression "all payer system." The law lists "financial elements" or categories of cost that by law must be included in hospital rates established by the system. Listed among these financial elements is: "...The reasonable cost of...the provision of health care services to individuals unable to pay for them for reasons of indigency; and bad debts, provided adequate recovery procedures are followed."

Beyond the level of detail found in the statute, New Jersey's hospital uncompensated care policy is provided in regulations. Regulations specify criteria to determine eligibility for medical indigency status. Criteria used are Medicaid (Title XIX) income criteria, and therefore those patients classified as medically indigent are *categorically* ineligible for Medicaid while having income below the Medicaid upper limit. Regulations define collection procedures to be followed before an account can be considered a reimburseable bad debt, and list preadmission, predischarge, and postdischarge interviewing and collection procedures that must be followed. They require that all usual collection efforts be used before an account can be considered a reimburseable bad debt. The means by which uncompensated care is paid

are also defined. Uncompensated care is paid by means of an "uncompensated care factor" used to adjust the rates of each hospital so that its paying patients will pay the *projected* cost of its nonpaying patients. Each hospital has its own uncompensated care factor based on its own projected rate of uncompensated care. Hospital specific factors range from less than 1.01 to more than 1.25, but average approximately 1.075. When, at year end, approved revenue for a year is defined through a procedure called "final reconciliation," most hospitals are allowed their actual (as opposed to projected) uncompensated care for the year. For hospitals that receive grants for uncompensated care and for public hospitals, an appropriate adjustment avoids duplicate payments and assures that public responsibilities are not shifted to the reimbursement system. Finally, uncompensated care is paid on the same basis as all other hospital care in New Jersey: a prospective DRG rate per case for inpatient services and a prospective price per visit or per service for outpatient services.

The rule by which uncompensated care is allocated to all payers or classes of payers is also defined in regulations: Uncompensated care is apportioned to payers or classes of payer based upon the percent of hospital gross charges *statewide* of each payer or class of payers. Thus, if a particular payer incurs 20% of hospital charges statewide, that payer is hereby responsible for 20% of uncompensated care statewide and, consequently, in each hospital. To effectuate this allocation, billing of each hospital to each payer is adjusted by means of "payer factors" specific both to hospitals and payers.

## Four Effects of the Reimbursement System

There are four unique results of this legal and regulatory framework developed by New Jersey. The New Jersey system finances only hospital uncompensated care; all payers participate on an equitable basis; each hospital collects its own uncompensated care; and continued all payer participation is not easily assured. Each of these facts has implications for the issues of access, equity and cost effectiveness.

First, the New Jersey system finances uncompensated care only in hospitals. Uncompensated care is financed through the New Jersey prospective rate setting system, which regulates the state's 90 short-term general, acute-care hospitals. The program does not insure individuals, so only care rendered by covered providers is included. Other providers are not included in the system and are not entitled to payment under its uncompensated care provision.

The State of Florida, which has attracted the attention of many states wrestling with how to pay for uncompensated care, provides an example of a different approach. In the absence of any state reimbursement control system, Florida uses an "assessment" or tax on hospital revenues to finance an expanded Medicaid program. The financing of uncompensated care in the two states is somewhat different, but the most notable difference involves the delivery of care. Florida provides a medical entitlement for the indigent which theoretically provides access to a full range of providers, the hospital being only one. New Jersey's "assessment" is not used to expand *direct* entitlements to the medically indigent. Instead, New Jersey has created an entitlement for hospitals based on the care they provide to the indigent.

This choice of entitlements has important implications both for the access it provides to the poor and the cost effectiveness of the care received. While improving access, the New Jersey system also limits that incremental additional access which it provides to hospital inpatient and outpatient settings. An entitlement provided directly to the poor theoretically could encompass a broader range of health care providers. Realistically, however, in most states, including New Jersey, Medicaid payment to nonhospital providers, especially physicians, is so low that Medicaid patients generally can only secure primary care in hospital outpatient settings. Possibly case management programs being initiated by state Medicaid programs in New Jersey and elsewhere will change this, but currently the range of care provided under the New Jersey entitlement for hospitals probably does not differ very much from what would be available under an expanded Medicaid program in New Jersey.

It is also important to remember that a hospital uncompensated care provision makes care available to more of the poor than would an expanded Medicaid program. Many uninsured families and individuals with incomes above the highest federally permitted Medicaid income limit are by any reasonable criteria unable to pay for hospital care. These families and individuals are "covered" under the bad debt component of New Jersey uncompensated care provision. The hospital providing care must attempt to collect, but would determine that collection is impossible, and write-off the account. Normal collection efforts are required (and are audited) because this provision is intended to help only those who truly cannot pay.

Thus, theoretically the entitlement for hospitals provided by the New Jersey system may offer the poor access to a narrower range of providers than would another kind of entitlement, but the system provides care to many

more of the poor than would be reached by any other program short of national health insurance. By entitling hospitals rather than individuals the New Jersey system accepted existing arrangements and found a way to finance them instead of trying to change them. Hospitals have provided both inpatient and ambulatory care for the poor for decades, but lack of financing for this care has been a growing problem. The access problem in New Jersey during the late 1970s was due more to the fact that the hospitals that specialized in treating the poor were nearing bankruptcy and closure than to any problems encountered by the poor in gaining access to hospitals. The New Jersey system was intended to solve this problem. The result has been continuation or expansion of care for the poor in those institutions where they are accustomed to seeking care.

Payment by the New Jersey system for uncompensated care provided by hospitals may also have implications for the issue of cost effectiveness. About one third of all uncompensated care reimbursed by the New Jersey system in 1983 was provided in hospital outpatient or ambulatory settings. In some instances other providers may offer comparable services at a lower price, but the New Jersey system can presently only provide uncompensated care reimbursement to regulated providers.

Even within the universe of hospitals, those that provide the bulk of the uncompensated care are the more costly ones. Of the 18 (out of a total of 90) hospitals that provided half of the total statewide uncompensated care in 1983, 12 were "major teaching" hospitals (according to New Jersey rate-setting criteria), four were "minor teaching" and only two were "non teaching." This may primarily result from the inner city location of many teaching hospitals, but it still raises the cost of providing care to the poor.

A second important fact about the New Jersey system is that all payers participate in uncompensated care costs, and participation is on the basis of payer share of hospital charges statewide. In New Jersey this means that Medicare pays about 45.5% of uncompensated care costs and the state Medicaid program pays about 8.5%. Blue Cross of New Jersey pays 22% and commercial insurance, health maintenance organizations, self-insured groups, small governmental payers and self-pay patients pay the remaining 24%.

Whether this policy is equitable raises a number of interesting public finance questions. Participation of each category of payer may imply a particular kind of assessment or "tax" for the financing of uncompensated care. Medicare funds come from the Social Security tax, Medicaid from federal and state taxes, other payers' contributions from premiums paid by employers or individuals and so on. However, what is important is that, in exchange

for this assessment, New Jersey's all payer system generates cost savings which demonstrably more than offset the amount of this assessment. In fact, the existence of demonstrated savings is the only basis on which Medicare and Medicaid continue to participate in the New Jersey system.

A second equity issue related to all payer sharing of uncompensated care is the issue of "payers within payers." A rate setting mechanism called a "payer factor" is used to assure that at each hospital each payer category pays for the appropriate amount of uncompensated care based on the statewide apportionment. However, within some payer categories there are multiple payers ("commercial/other" and "health maintenance organization" for example), and within some payers there are multiple "experienced rated" policies. An experience rated policy is one in which an employer's premium in a given year is a function of the employers' total insured health care costs the previous year. While the payer factors ensure that each category of payer pays its appropriate share of uncompensated care, no such enforcement exists for payers within categories. Some individual payers or experience rated employers may pay more or less than a share of uncompensated care proportional to their share of hospital charges statewide.

A third important fact with equity implications is that each hospital is responsible for collecting enough to finance its own uncompensated care. The statewide average percent add-on to the rates of those who pay necessary to collect approved reimbursement for uncompensated care costs ($239 million in 1983) is approximately 7.5%. That is, the average hospital's rates are 7.5% higher than they would be if there were no reimbursement for uncompensated care. However, on a hospital-specific basis the percent add-on for uncompensated care ranges from below 1% to more than 25%. Therefore, if price competition is a factor in the financial success of hospitals, those hospitals that treat a disproportionate number of poor uninsured patients are at a disadvantage. At this point there is no evidence that any hospitals are suffering as a result of a price competitive disadvantage. However, if there is a rise, as is projected, in the market share of such payers as health maintenance and preferred provider organizations that have the ability to "broker" patients, price competition may intensify. In this event, hospitals that provide a large share of the care to the indigent may be priced out of the market.

Finally, a fourth fact about the New Jersey system is that all payer participation is not easily assured. Medicare and Medicaid participate because New Jersey has a waiver from the federal government. New Jersey's waiver is continued on the basis of assurances given that Medicare payments under the New Jersey system will not exceed what would be paid under usual

Medicare principles, which do not permit payment for uncompensated care. To the extent that federal payments based on Medicare principles for hospital care decline as expected, at least in the short run, New Jersey's waiver is in jeopardy. Without federal participation, up to 54% of New Jersey's uncompensated care could be "at risk."

A second category of payers whose participation cannot be guaranteed in full is made up of the payers that have the ability to "broker" patients. Health maintenance and preferred provider organizations have some ability to choose the hospitals where their patients are admitted. Other things being equal, they can be expected to choose the hospitals with lower prices. Hospitals carrying heavy uncompensated care loads will be unable to offer competitive prices even if they are relatively efficient. The end result may be that these payers will use hospitals with little uncompensated care, and thereby avoid their statewide share of the total obligation. The extent to which this problem will materialize depends in part on the market penetration of health maintenance and preferred provider organizations. At present they have only about 5% of the market, but their share is increasing and may be quite substantial within a few years.

The danger in the potential withdrawal of federal and certain private payers is that in a few years New Jersey's "all payer financing of uncompensated care" could become "some payer financing of some uncompensated care." The shortfall would have to be made up from another source such as private payers or state tax revenue or go unpaid altogether.

## Discussion

New Jersey has begun to address many of these issues. Among the proposals considered is pooling of uncompensated care with each hospital using a flat statewide percent add-on as a collection mechanism; that is, hospitals would mark up their rates by a percent equal to the statewide weighted average for hospital-specific uncompensated care factors. Hospitals with approved uncompensated care less than that collected through the add-on would pay the difference into a "pool." Those with approved amounts in excess of the add-on would bill the pool. This approach would eliminate the unfair competitive disadvantage of hospitals with high uncompensated care and would also prevent price shopping by health maintenance and preferred provider organizations from resulting in their underpaying their proportional share of uncompensated care. In addition, if the federal contribution is reduced and the state finds that it must shift more of the uncompensated care burden to private payers, the problems of competitive disadvantage and price shopping, in the absence of a pool, becomes much

worse. If the entire federal share of uncompensated care were shifted to private payers, 18 of New Jersey's 90 hospitals would need to "mark up" the rates of private payers by more than 25%, six by more than a third, two by more than half and one by more than 100%. A pool that distributes the financing of uncompensated care more equitably would help to alleviate this problem.

The problem of a large federal shortfall, if it occurs, may not be addressed simply through a pooling mechanism. Those paying for the federal shortfall will likely raise the question of cost. If it is found that less than all of the existing commitment can be met, the issue of cost will be forced. In view of the settings in which uncompensated care, particularly ambulatory care, is typically provided, the question of cost can reasonably be raised. It may be possible to find lower cost alternatives to outpatient service areas of major teaching hospitals. Accordingly, New Jersey is studying alternative financing and delivery strategies intended to provide more cost-effective care for the poor. These solutions, however, require time to develop. In the meantime, the challenge will be to preserve the gains that have been made by the New Jersey system. With the all payer system New Jersey removed the financial barrier to caring for the indigent in hospitals. That in itself is an achievement worth preserving.

Finally, to suggest an answer to the question posed by the symposium: Has New Jersey found an efficient and ethical way to provide indigent care? New Jersey has found a way. Efficiency and perfect equity are elusive goals, made more elusive by the rapid change presently occurring in the health care field. Most other states and certainly the federal government have yet to find a way—efficient and ethical or otherwise. New Jersey is in the unique position of attempting to make a functioning system that pays for uncompensated care more efficient and more ethical.

## Appendix

While New York has chosen to discontinue its Medicare waiver and its all payer system, New Jersey retains its waiver. New York finances hospital uncompensated care without a waiver by charging an assessment on hospitals' Medicare revenue, and by including an additional amount in the rates of private payers. New Jersey accomplishes the same goal by including the cost of uncompensated care in the rates of all payers including Medicare. New Jersey can do this because under its waiver Medicare pays hospital rates established by the state. With few exceptions, other states do not have any comprehensive program for payment of hospital uncompensated care or for assuring that the poor will have access to care.